

## **EXHIBIT 13**

UNITED STATES DISTRICT COURT  
DISTRICT OF MASSACHUSETTS

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IN RE: FRESINIUS  
GRANUFLO/NATURALYTE DIALYSATE  
PRODUCTS LIABILITY LITIGATION

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MDL NO. 1:13-MD-2428-DPW

**PLAINTIFF FACT SHEET**

In completing this Plaintiff Fact Sheet, you must provide information that is true and correct to the best of your knowledge. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. You must also supplement your responses in the event that you later learn or receive additional information that is responsive to any of the information requests below. In the event the Plaintiff Fact Sheet does not provide you with enough space for you to complete your responses or answers, please attach additional sheets if necessary. Please identify any documents that you are producing as responsive to a question or request by bates-stamp identifiers.

If you are completing this Plaintiff Fact Sheet in a representative capacity, please respond to the questions on behalf of the person you are representing whom you allege was exposed to, or treated with, GranuFlo and/or NaturaLyte. Whether you are completing this fact sheet for yourself or for someone else, please assume that "you" or "Plaintiff" means the person who was exposed to, or treated with, GranuFlo and/or NaturaLyte.

This Fact Sheet shall be completed in accordance with Case Management Orders 2 and 3. The information provided is confidential and subject to the protective order.

*[Note: In an effort to be forthcoming and to provide non-privileged information, the information provided in this fact sheet is, by necessity, not based solely upon the knowledge of the plaintiff and includes non-privileged information assembled and collected by the parties' attorneys which may not be known to the executing party.]*

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**I. CASE INFORMATION**

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Caption: \_\_\_\_\_ Date Filed: \_\_\_\_\_

Docket No. (Including Court): \_\_\_\_\_

Plaintiff's Attorney and Contact Information, Including Telephone Number:

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Name, Title and Contact Information of Each Person Providing Responses to this Fact Sheet:

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## II. PLAINTIFF'S INFORMATION

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Full Name of Plaintiff: \_\_\_\_\_

Last Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Plaintiff's FMS Medical Record Number, also known as the Patient Identification Number:

\_\_\_\_\_

If no FMS Medical Record Number, please provide the following information:

a. Plaintiff's Medicare Identification Number: \_\_\_\_\_

b. The last four digits of Plaintiff's Social Security Number: \_\_\_\_\_

Please provide the following information:

1. Date of Death/Injury: \_\_\_\_\_

2. Location of Death/Injury (Clinic, Home, Hospital, including name of clinic or hospital, if applicable, and complete address) \_\_\_\_\_

\_\_\_\_\_

3. Cause of Death/Injury asserted by Plaintiff as of the date of this Fact Sheet:

Non-Cardiac Event or Condition

Cardiac Event or Condition

Acute Coronary Syndrome

Arrhythmia

Bradycardia Arrhythmia

Cardiomegaly

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Cardiomyopathy  
Congestive Heart Failure  
Coronary Artery Disease  
Coronary Occlusion  
Coronary Thrombosis  
Myocardial Infarction  
Sudden Cardiac Arrest  
Cardiopulmonary Arrest  
Tachycardia Arrhythmia  
Atrial Fibrillation  
Ventricular Fibrillation  
Other (please specify)  
Unknown

Do not know



4. Was Autopsy Performed? \_\_\_\_\_ If So, Date \_\_\_\_\_

**ATTACH DEATH CERTIFICATE AND AUTOPSY REPORT, IF APPLICABLE.**

5. Please provide a list of all treating physicians or healthcare providers who provided medical care to Plaintiff within the twelve (12) months preceding the injury/death, including but not limited to all primary care physicians, cardiologists, nephrologists, and hospitals.

a. Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Type of Provider: \_\_\_\_\_

b. Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Type of Provider: \_\_\_\_\_

c. Provider Name: \_\_\_\_\_

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Provider Address: \_\_\_\_\_

Type of Provider: \_\_\_\_\_

ATTACH ADDITIONAL SHEETS AS NECESSARY

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### III. REPRESENTATIVE/DEMOGRAPHIC INFORMATION

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1. Name of Representative: \_\_\_\_\_

2. Relationship to Plaintiff (if applicable): \_\_\_\_\_

3. Address: \_\_\_\_\_

4. Appointed Position (if applicable): \_\_\_\_\_

5. Court of Appointment: \_\_\_\_\_

6. Date of Appointment: \_\_\_\_\_

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### IV. DIALYSIS HISTORY

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1. List all dialysis clinics and/or dialysis facilities, including hospital-operated acute and chronic dialysis units, and including home hemodialysis, where the Plaintiff received dialysis treatments.

a. Dialysis Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

b. Dialysis Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

c. Dialysis Clinic Name: \_\_\_\_\_

Clinic Address: \_\_\_\_\_

ATTACH ADDITIONAL SHEETS AS NECESSARY

2. Please provide the date of Plaintiff's last dialysis treatment prior to or at the time of death/injury: \_\_\_\_\_

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a. Please provide the name and address of the dialysis provider: \_\_\_\_\_

\_\_\_\_\_  
**PLEASE PROVIDE ALL NON-PRIVILEGED, RELEVANT MEDICAL RECORDS,  
INCLUDING BUT NOT LIMITED TO DIALYSIS TREATMENT RECORDS, IN YOUR  
POSSESSION, CUSTODY OR CONTROL THAT HAVE NOT ALREADY BEEN  
PRODUCED PURSUANT TO CASE MANAGEMENT ORDER NO. 3**

**CERTIFICATION**

I declare that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge and that I have supplied all requested documents to the extent that such documents are in my possession, custody and control (including the custody and control of my lawyers).

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Signature

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Print Name

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Date

**AUTHORIZATIONS**

**Provide ONE (1) SIGNED ORIGINAL copy of each of the records authorization forms attached as Ex. A. These authorization forms will authorize the records vendor selected by the parties to obtain those records from the providers identified within this Plaintiff Fact Sheet.**

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Plaintiff's Counsel